International Journal of Medical and Pharmaceutical Research

Online ISSN-2958-3683 | Print ISSN-2958-3675
Frequency: Bi-Monthly
Available online on: https://ijmpr.in/

Original Article

Symptom Dimensions and Insight in Obsessive Compulsive Disorder: A Cross-Sectional Study in A Tertiary Care Hospital at Kolkata

Dr. Arpita Laha[1], Dr. Siddhartha Sankar Saha[2], Dr. Ashis Debanth[3]

[1]Senior Resident Doctor, MD, Department of Psychiatry, Prafulla Chandra Sen Government Medical College and Hospital Arambagh, Hooghly, West Bengal, PIN-712601

[2]Assistant Professor, MD, Department of Psychiatry, Nil Ratan Sarkar Medical College and Hospital, Kolkata, West Bengal 700014.

[3]Associate Professor, MD, Department of Psychiatry, Nil Ratan Sarkar Medical College and Hospital, Kolkata, West Bengal 700014.

OPEN ACCESS

Corresponding Author:

Arpita Laha
Designation-MBBS, MD Psychiatry
Institute/College-Prafulla Chandra Sen Government Medical College and Hospital Arambagh, Hooghly, West Bengal,PIN-712601

Received: 21-06-2026
Accepted: 10-07-2026
Available online: 25-07-2026

ABSTRACT

Introduction: Obsessive–Compulsive Disorder (OCD) is a chronic psychiatric disorder characterized by intrusive thoughts (obsessions) and repetitive behaviors (compulsions). Symptom dimensions and insight levels vary widely among patients, impacting the severity and prognosis. Understanding these patterns is crucial for personalized treatment.

Aims and Objectives: This study aims to assess the distribution of OCD symptom dimensions and evaluate the level of insight in a sample of patients at a tertiary care hospital in Kolkata.

Materials and Methods: This institution-based, descriptive observational study was conducted at the Psychiatry OPD of NRS Medical College and Hospital, Kolkata, over 12 months. The study included 65 OCD patients. Data were collected on demographic and clinical variables, including age, sex, socio-economic status, education, YBOCS score, insight level, and specific OCD symptoms such as contamination and hoarding.

Results: In the study of 65 participants, OCD severity (YBOCS) was mostly severe (31/65, 47.7%), followed by moderate (22/65, 33.8%), extreme (9/65, 13.9%), and mild (3/65, 4.6%), with insight predominantly fair (29/65, 44.6%) or good (25/65, 38.5%). Severity showed no significant associations with age, sex, religion, residence, socio-economic status, family type, or illness duration. Younger participants (≤40 years) predominated across most severity levels and symptom dimensions, with collecting/hoarding (2/2, 100%) significantly more common in this group ($p = 0.042$). Socio-economic status influenced certain symptom dimensions: collecting/hoarding (middle 50%, lower/lower middle 50%, $p = 0.031$), contamination (upper/upper middle 45.8%, middle 8.3%, lower/lower middle 45.8%), miscellaneous (lower/lower middle 88.9%), harm-related (lower/lower middle 75%), ordering/symmetry (evenly distributed), and sexual/religious (lower/lower middle 60%).

Conclusion: OCD symptoms are influenced by various demographic factors such as age, sex, socio-economic status, and family type, which can shape the manifestation and severity of symptoms. Insight levels, which vary significantly among individuals, also play a crucial role in symptom severity and treatment response.

Keywords: *Obsessive-Compulsive Disorder (OCD), Symptom Dimensions, Insight, Y-BOCS, Socio-economic Status.*

INTRODUCTION

Obsessive-compulsive disorder (OCD) is a chronic psychiatric disorder characterized by persistent, distressing obsessive thoughts and compulsions. Lifetime prevalence of the disorder is 1-3% and tends to be cross-culturally robust [1, 2]. OCD is characterized by obsessions and compulsions, which consume a significant amount of time and causes notable distress

and impairment. Obsessions refer to intrusive and repetitive thoughts, urges, or mental images that are challenging to control. These thoughts often lack a clear purpose and are accompanied by distress [3]. Compulsions involve repetitive actions or mental events that individuals with OCD feel compelled to perform to alleviate the distress caused by the obsessions or to prevent a feared consequence from occurring [3]. Moreover, individuals with OCD may also involve in avoidance behaviors of obsession-triggering conditions [2].

There is wide variation in the thematic content of obsessions and compulsions. Empirical evidence suggests that the diversity in OCD symptoms can be reduced to a fewer number of symptom dimensions; as a result OCD is increasingly seen as a dimensional disorder [3]. Most widely used approach to reduce the heterogeneity is to generate symptom dimensions based on the factor analysis of the symptoms such as the ones generated by the Yale–Brown Obsessive–Compulsive Scale (YBOCS) symptom checklist [4].

Generally, OCD has been widely linked to the impression of insight. Insight represents a continuum that ranges from a lack of awareness to being fully aware of the absurdity of the obsessions and compulsions [5]. Insight is generally considered to be a multidimensional concept that encompasses different components, such as the capacity to recognize symptoms, the acknowledgment of one's own disorder, the capacity to identify and label unusual mental events as pathologic, the specific attribution of symptoms, the consequences of the disorder, and treatment adherence [6]. In clinical practice, insight refers to a patient's comprehension of his or her symptoms and/or disorder. There is no general consensus on what the object of insight should be: symptom awareness or general awareness of the disorder. Insight can be evaluated from a unidimensional and multidimensional perspective. The conceptualization of insight has implications for research and it also has practical clinical applications. Diagnostic

and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), provides 3 specifiers for level of insight: with good or fair insight, with poor insight, and with absent insight/delusional beliefs [7]. It is estimated that poor insight affects 21% to 36% of patients with OCD [8- 12], while 4% or fewer of patients with OCD have absent insight or delusional beliefs. Poor insight is common reasons many people with mental illness do not seek proper treatment.

The symptoms used to define OCD are heterogenous and include various intrusive thoughts and preoccupations, rituals, and compulsions. Two individuals with OCD may have totally different and non-overlapping symptom patterns. Individuals with OCD vary in the degree of insight they have about the accuracy of the beliefs that underline their Obsessive Compulsive symptoms. There are only few studies determining the association between symptom dimensions and insight in Obsessive Compulsive Disorder, especially in eastern India. Hence the study was planned to study the symptom dimensions of Obsessive Compulsive Disorder and insight among patients at a tertiary level healthcare facility.

The present study aims to comprehensively examine the symptom dimensions of Obsessive–Compulsive Disorder (OCD) and evaluate their relationship with patients' insight within a tertiary healthcare setting in West Bengal. Specifically, it seeks to explore the socio-demographic characteristics of individuals diagnosed with OCD attending the Psychiatry Outpatient Department of NRS Medical College & Hospital, Kolkata; identify the predominant symptom dimensions within this population; assess the level of insight among these patients; and ultimately determine how these symptom dimensions relate to both socio-demographic factors and the degree of insight, thereby contributing to a deeper understanding of clinical variability in OCD.

MATERIALS AND METHODS

Study design: An institution based descriptive observational study with cross-sectional design was conducted.
Place of study: The study was conducted at the Psychiatry OPD at NRS Medical College and Hospital, Kolkata.
Period of study: Necessary data for the study were collected over a period of 12 months from
Study Variables: Age, sex, religion, residence, socio-economic status, education level, occupation, family type, duration of illness, YBOCS score, insight level, miscellaneous, contamination, symptom dimension, collecting and hoarding.
Sample size: 65 patients diagnosed with Obsessive-Compulsive Disorder (OCD).

TOOLS USED IN THE STUDY:

1. Semi structured questionnaire used routinely to assess the socio demographic and other relevant details.
2. ICD 10
3. MINI INTERNATIONAL NEUROPSYCHIATRIC INTERVIEW(M.I.N.I)
4. Yale- Brown Obsessive Compulsive scale(Y-BOCS)
5. Brown Assessment of Beliefs scale(BABS) for assessment of insight level.

Inclusion Criteria:

- Diagnosed with Obsessive-Compulsive Disorder (OCD) based on ICD-10/DSM-5 criteria.
- Age: 18-65 years.
- Both genders included.

Exclusion Criteria:

- Severe comorbid psychiatric disorders (e.g., schizophrenia, bipolar disorder).
- Current substance abuse or withdrawal.
- Medical conditions contraindicating participation (e.g., severe cardiovascular disease, acute infections).
- Cognitive impairment or inability to consent.

Statistical Analysis: Data were analyzed using SPSS version 22.0. Descriptive statistics, including frequencies, percentages, means, and standard deviations, were used to summarize demographic and clinical characteristics. The distribution of symptom dimensions and insight levels was evaluated. For comparison of continuous variables, paired t-tests were used to assess changes in blood pressure before and after treatment. The relationship between symptom dimensions and insight levels was assessed using correlation analysis. A p-value < 0.05 was considered statistically significant.

Ethics approval and consent to participate:Ethical approval to conduct the study was obtained from the Instuitional Ethics Committee of NRS Medical College and Hospital.Written informed consent was obtained from all participants before the interview.

RESULT

Table 1: YBOCS Score and Insight Level Distribution

		Number of Individuals	Percentage (%)
YBOCS Score	**Mild symptoms**	3	4.6
	Moderate symptoms	22	33.8
	Severe symptoms	31	47.7
	Extreme symptoms	9	13.9
	Total	65	100
Insight Level	**Poor insight**	9	13.8
	Fair insight	29	44.6
	Good insight	25	38.5
	Excellent insight	2	3.1
	Total	65	100

Table 2: Association of YBOCS Severity with Demographic Variables (Block 2)

Variable	Category	Mild (n, %)	Moderate (n, %)	Severe (n, %)	Extreme (n, %)	p-value
Age (years)	≤40	8 (88.9%)	25 (86.2%)	20 (80%)	2 (100%)	0.812
	>40	1 (11.1%)	4 (13.8%)	5 (20%)	0	
Sex	Female	7 (77.8%)	14 (48.3%)	15 (60%)	1 (50%)	0.455
	Male	2 (22.2%)	15 (51.7%)	10 (40%)	1 (50%)	
Religion	Hindu	6 (66.7%)	16 (55.8%)	15 (60%)	1 (50%)	0.927
	Muslim	3 (33.3%)	13 (44.2%)	10 (40%)	1 (50%)	
Residence	Rural	5 (55.6%)	12 (41.4%)	14 (56%)	0	0.362
	Urban	4 (44.4%)	17 (58.6%)	11 (44%)	2 (100%)	
Socio-economic Status	Upper	1 (11.1%)	4 (13.8%)	0	0	0.272
	Upper middle	1 (11.1%)	6 (20.7%)	4 (16%)	0	
	Middle	1 (11.1%)	4 (13.8%)	7 (28%)	0	
	Lower middle	5 (55.6%)	7 (24.1%)	6 (24%)	0	
	Lower	1 (11.1%)	8 (27.6%)	8 (32%)	2 (100%)	
Family Type	Joint	3 (33.3%)	12 (41.4%)	6 (24%)	0	0.417
	Nuclear	6 (66.7%)	17 (58.6%)	19 (76%)	2 (100%)	
	<6	1 (11.1%)	7 (24.1%)	3 (12%)	1 (50%)	0.496
Duration of Illness (Months)	6–11	2 (22.2%)	6 (20.7%)	9 (36%)	1 (50%)	
	12–24	6 (66.7%)	16 (55.2%)	13 (52%)	0	

Table 3: Symptom Dimension Distribution by Age, Sex, Religion, Residence, Socio-Economic Status, and Family Type

Symptom Dimension	Age ≤ 40 (n, %)	Age > 40 (n, %)	Total (n, %)	p-value

Collecting and Hoarding	2 (100%)	-	2 (100%)	0.042
Contamination	17 (70.8%)	7 (29.2%)	24 (100%)	
Miscellaneous	6 (66.7%)	3 (33.3%)	9 (100%)	
Harm and Related	8 (100%)	-	8 (100%)	
Ordering/Symmetry	12 (100%)	-	12 (100%)	
Sexual and Religious	10 (100%)	-	10 (100%)	
Collecting and Hoarding	1 (50%)	1 (50%)	2 (100%)	0.001
Contamination	22 (91.7%)	2 (8.3%)	24 (100%)	
Miscellaneous	5 (55.6%)	4 (44.4%)	9 (100%)	
Harm and Related	3 (37.5%)	5 (62.5%)	8 (100%)	
Ordering/Symmetry	3 (25%)	9 (75%)	12 (100%)	
Sexual and Religious	3 (30%)	7 (70%)	10 (100%)	
Collecting and Hoarding	2 (100%)	-	2 (100%)	0.081
Contamination	12 (50%)	12 (50%)	24 (100%)	
Miscellaneous	8 (88.9%)	1 (11.1%)	9 (100%)	
Harm and Related	2 (25%)	6 (75%)	8 (100%)	
Ordering/Symmetry	7 (58.3%)	5 (41.7%)	12 (100%)	
Sexual and Religious	7 (70%)	3 (30%)	10 (100%)	
Collecting and Hoarding	-	2 (100%)	2 (100%)	0.013
Contamination	15 (62.5%)	9 (37.5%)	24 (100%)	
Miscellaneous	6 (66.7%)	3 (33.3%)	9 (100%)	
Harm and Related	4 (50%)	4 (50%)	8 (100%)	
Ordering/Symmetry	6 (50%)	6 (50%)	12 (100%)	
Sexual and Religious	-	10 (100%)	10 (100%)	
Collecting and Hoarding	1 (50%)	1 (50%)	2 (100%)	0.002
Contamination	13 (54.2%)	11 (45.8%)	24 (100%)	
Miscellaneous	-	9 (100%)	9 (100%)	
Harm and Related	5 (62.5%)	3 (37.5%)	8 (100%)	
Ordering/Symmetry	1 (8.3%)	11 (91.7%)	12 (100%)	
Sexual and Religious	1 (10%)	9 (90%)	10 (100%)	

Table4: Symptom Dimension Distribution by Socio-Economic Status

Symptom Dimension	Upper/Upper Middle (n, %)	Middle (n, %)	Lower Middle/Lower (n, %)	Total (n, %)	p-value
Collecting and Hoarding	-	1 (50%)	1 (50%)	2 (100%)	0.031
Contamination	11 (45.8%)	2 (8.3%)	11 (45.8%)	24 (100%)	
Miscellaneous	1 (11.1%)	-	8 (88.9%)	9 (100%)	
Harm and Related	1 (12.5%)	1 (12.5%)	6 (75%)	8 (100%)	
Ordering/Symmetry	3 (25%)	4 (33.3%)	5 (41.7%)	12 (100%)	
Sexual and Religious	-	4 (40%)	6 (60%)	10 (100%)	
Collecting and Hoarding	-	-	2 (100%)	2 (100%)	0.067
Contamination	4 (16.7%)	6 (25%)	14 (58.3%)	24 (100%)	
Miscellaneous	1 (11.1%)	6 (66.7%)	2 (22.2%)	9 (100%)	
Harm and Related	3 (37.5%)	1 (12.5%)	4 (50%)	8 (100%)	
Ordering/Symmetry	-	3 (25%)	9 (75%)	12 (100%)	
Sexual and Religious	4 (40%)	2 (20%)	4 (40%)	10 (100%)	

Figure 1: YBOCS Score and Insight Level Distribution

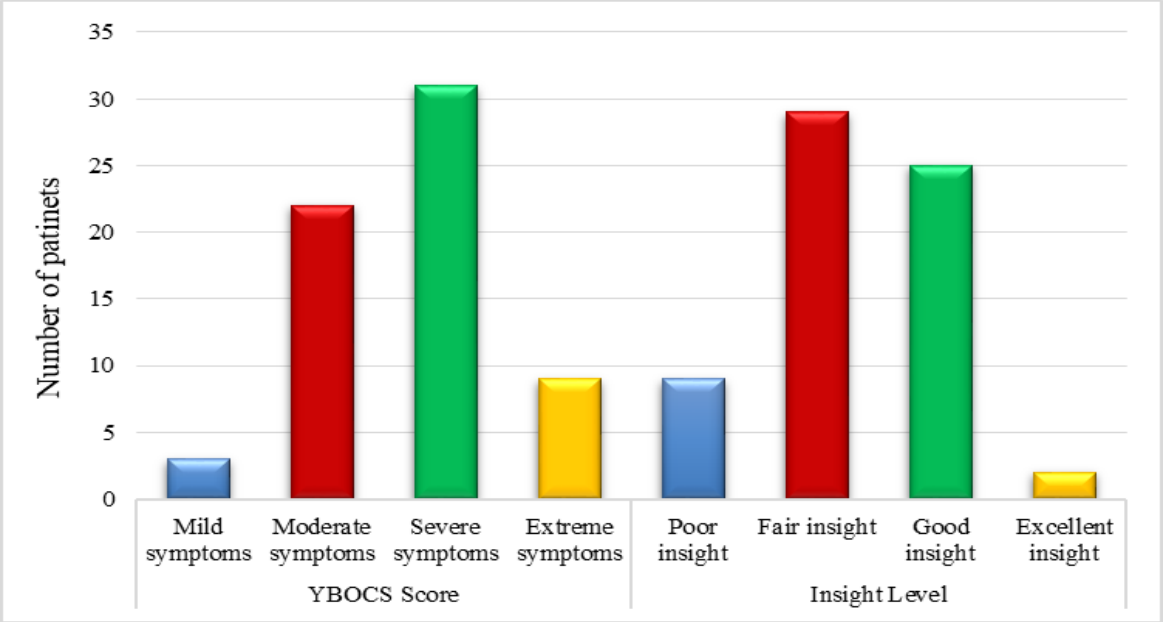
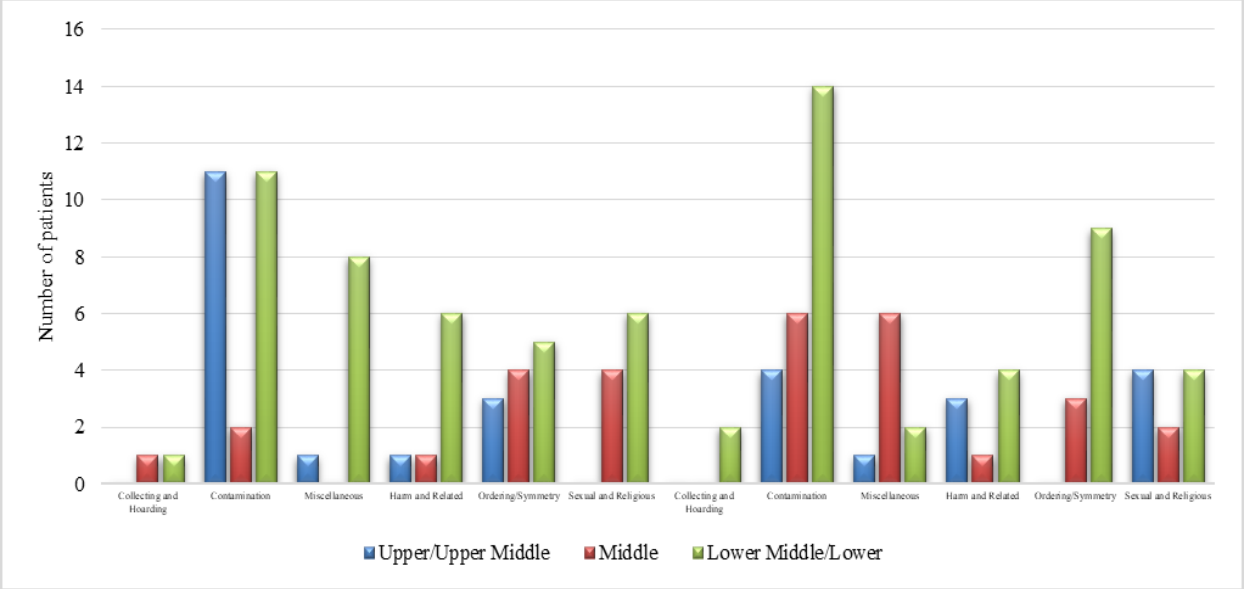


Figure 2: Symptom Dimension Distribution by Socio-Economic Status



In the present study, the distribution of obsessive-compulsive symptom severity, as assessed by the Yale-Brown Obsessive-Compulsive Scale (YBOCS), indicated that nearly half of the participants exhibited severe symptoms (31/65, 47.7%), followed by moderate symptoms (22/65, 33.8%), extreme symptoms (9/65, 13.9%), and mild symptoms (3/65, 4.6%). Insight levels were predominantly fair (29/65, 44.6%), with good insight reported by 25 participants (38.5%), poor insight by 9 participants (13.8%), and excellent insight by 2 participants (3.1%). All patients having symptom dimension of Collecting and Hoarding had poor insight and excellent insight was found with sexual and religious symptom dimension.

The association of YBOCS severity with demographic variables did not reveal statistically significant differences. Regarding age, the majority of participants with mild (8/9, 88.9%), moderate (25/29, 86.2%), severe (20/25, 80%), and extreme (2/2, 100%) symptoms were ≤40 years, while those >40 years comprised 11.1% of mild, 13.8% of moderate, and 20% of severe cases ($p = 0.812$). Similarly, sex distribution was not significantly associated with severity ($p = 0.455$), with females accounting for 77.8% of mild, 48.3% of moderate, 60% of severe, and 50% of extreme cases, and males comprising 22.2%, 51.7%, 40%, and 50% in the respective categories. Religion also showed no significant association ($p = 0.927$), with Hindus representing 66.7% of mild, 55.8% of moderate, 60% of severe, and 50% of extreme cases. Residence ($p = 0.362$) indicated that rural participants made up 55.6% of mild, 41.4% of moderate, 56% of severe, and none of the extreme cases, whereas urban participants accounted for 44.4%, 58.6%, 44%, and 100%, respectively.

Socio-economic status did not significantly influence severity (p = 0.272); most severe cases were from lower SES (8/31, 32%) and middle SES (7/31, 28%), while extreme cases were exclusively from lower SES (2/2, 100%). Mild cases were distributed across upper (1/3, 11.1%), upper middle (1/3, 11.1%), middle (1/3, 11.1%), lower middle (5/9, 55.6%), and lower (1/9, 11.1%) SES categories. Family type (p = 0.417) showed nuclear families constituted 66.7% of mild, 58.6% of moderate, 76% of severe, and 100% of extreme cases, with joint families comprising the remainder. Duration of illness was not significantly associated with severity (p = 0.496); for <6 months, participants represented 11.1% of mild, 24.1% of moderate, 12% of severe, and 50% of extreme cases, while durations of 6–11 months and 12–24 months accounted for 22.2% and 66.7% of mild, 20.7% and 55.2% of moderate, and 36% and 52% of severe cases, respectively.

Symptom dimension analysis revealed significant age-related differences. Collecting and hoarding symptoms were more common in younger participants (2/2, 100%; p = 0.042), whereas contamination symptoms were present in both age groups but predominantly in ≤40 years (17/24, 70.8%) compared to >40 years (7/24, 29.2%). Harm-related, ordering/symmetry, and sexual/religious symptoms were exclusively reported by participants ≤40 years in some analyses (8/8, 100%; 12/12, 100%; 10/10, 100%) but showed a shift toward older participants in other subgroups, such as harm-related (5/8, 62.5%) and ordering/symmetry (9/12, 75%) symptoms. Miscellaneous symptoms were present across age groups with a slight predominance in ≤40 years (6/9, 66.7%).

Socio-economic status was significantly associated with certain symptom dimensions. Collecting and hoarding occurred in 1/2 (50%) participants in middle SES and 1/2 (50%) in lower/lower middle SES (p = 0.031). Contamination symptoms were distributed as 11/24 (45.8%) in upper/upper middle, 2/24 (8.3%) in middle, and 11/24 (45.8%) in lower/lower middle SES groups. Miscellaneous symptoms were predominantly seen in lower/lower middle SES (8/9, 88.9%), while harm-related symptoms were highest in lower/lower middle SES (6/8, 75%). Ordering/symmetry was more evenly distributed (upper/upper middle: 3/12, 25%; middle: 4/12, 33.3%; lower/lower middle: 5/12, 41.7%), and sexual/religious symptoms were seen in 6/10 (60%) of lower/lower middle SES participants.

DISCUSSION

In the present study, nearly half (47.7%) of participants scored in the 'severe' range on the Yale-Brown Obsessive Compulsive Scale (YBOCS), with an additional 13.9% in the 'extreme' range, indicating a predominantly high level of OCD severity in our sample. This distribution partly aligns with prior clinical studies, though some report lower proportions of "severe" presentations. For instance, a study from West Bengal involving urban, semi-rural, and rural participants found that while the bulk of cases fell into moderate-to-severe categories, the proportion in the most severe category was comparatively lower [13]. Similarly, another outpatient cohort (N = 45) reported a mean YBOCS total score of 25.86 ± 8.07, with dimension-specific prevalence showing contamination/cleaning (≈ 89%) and symmetry/ordering (≈ 62%) as the most common symptom clusters — but only 11.11% reported aggressive obsessions and 22.22% sexual/religious obsessions [14].

Notably, while our sample showed high rates of severe symptoms, insight levels were mostly fair (44.6%) or good (38.5%), with only a small fraction demonstrating excellent insight

(3.1%). This trend resonates with findings from a 2016 study at a tertiary center in Ranchi (N = 40), which reported better insight correlated significantly with lower severity across most symptom dimensions (excluding hoarding and sexual/religious dimensions) [15]. Their results underscore that insight may vary according to symptom dimension, and that better insight often coincides with less severe OCD presentations [15].

Regarding symptom dimensions, our data revealed dominance of contamination, ordering/symmetry, sexual/religious, and harm-related symptoms, particularly among younger participants (≤ 40 years), and a relative under-representation of hoarding/collecting. This distribution is in broad agreement with the factor-analytic literature which commonly identifies four primary dimensions: contamination/cleaning, symmetry/ordering, aggressive/checking (including harm-related), and hoarding — with hoarding typically being the least frequent dimension [16,17]. In a large item-level factor analysis of 1,224 OCD patients, the five-factor structure (taboo, contamination/cleaning, doubts, superstitions/rituals, symmetry/hoarding) revealed that both contamination and symmetry/hoarding dimensions showed heritability and shared genetic variance with overall severity [16].

However, the relative frequency of specific dimensions in our sample appears weighted more toward contamination, symmetry and aggressive/sexual/religious symptoms than in some Western samples, where symptom presentation may vary by culture, age, and gender [18]. A recent quantitative review encompassing 51 studies (total N = 9,404) found that while many symptom presentations vary across cultures and age groups, ordering/symmetry and contamination/cleaning tend to have consistent prevalence across cultural settings. They also noted that symptom presentation differences across gender were modest, except that sexual obsessions tended to be more common in samples with higher male proportions [18]. Our findings — with high contamination and symmetry, and substantial sexual/religious and harm-related symptoms — broadly fit these global trends, though the prominence of sexual/religious and harm-related symptoms might reflect cultural or sample-specific factors.

Overall, the present study's high proportion of severe and extreme cases, predominant contamination, symmetry/ordering, harm-related and sexual/religious symptom dimensions, and modest but nontrivial insight, aligns in part with prior Indian and international OCD literature — particularly those that report contamination and symmetry as among the most

frequent dimensions, and note variation across studies in dimension prevalence likely due to sample, cultural, and methodological differences. This suggests that while core OCD symptom structures may be universal, their relative expression (severity, dimension distribution, insight) can vary significantly with local sociocultural context, sample selection, and assessment methodology.

The results also support the dimensional nature of insight ranging from poor insight for hoarding which can be explained on the basis of ego syntonicity and excellent insight for sexual and religious compulsion which can be explained by the fact that sex is still considered a taboo in India and thought of sex is perceived as ego dystonic and hence well preserved insight.Insight for contamination is in between the two extremities which is supported by the fact that cleanliness has special place in our society however when done in excess is often perceived as alien to one's nature.

CONCLUSION

We conclude that obsessive-compulsive disorder in the sampled population is predominantly severe, with most individuals exhibiting fair to good insight. Contamination, ordering/symmetry, sexual/religious, and harm-related symptom dimensions were the most commonly observed, particularly among younger adults, while hoarding and miscellaneous symptoms were less frequent. Socio-economic factors appeared to influence the distribution of certain symptom types, whereas other demographic variables such as sex, religion, residence, and family type showed minimal impact on overall severity. Overall, these findings highlight that OCD presents with distinct dimension-specific patterns and varying levels of insight, emphasizing the importance of comprehensive assessment. Understanding these patterns can guide targeted, individualized therapeutic strategies, including cognitive-behavioral therapy and pharmacological management, to improve clinical outcomes and patient insight.

Study Limitation:

1. Cross sectional design restricts the ability to infer causal relationships.
2. The sample was drawn from a single tertiary care hospital which may limit the generalizability of the findings to a broader setting.
3. Short duration of the study may hamper the findings.

REFERENCES

1. Staley, D., & Wand, R. R. (1995). Obsessive-Compulsive Disorder: A review of the cross-cultural epidemiological literature. Transcultural Psychiatric Research Review, 32, 103-136.
2. Strom NI, Soda T, Mathews CA, Davis LK. A dimensional perspective on the genetics of obsessive-compulsive disorder. Transl Psychiatry. 2021 Jul 21;11(1):401.
3. Mataix-Cols, David & Rosário-Campos, Maria & Leckman, James. (2005). A Multidimensional Model of Obsessive-Compulsive Disorder. The American journal of psychiatry. 162. 228-38.
4. Goodman WK, Price LH, Rasmussen SA, et al. The Yale-Brown Obsessive Compulsive Scale. II. Validity. Arch Gen Psychiatry. 1989;46(11):1012-1016.
5. Stein DJ, Costa DLC, Lochner C, Miguel EC, Reddy YCJ, Shavitt RG, van den Heuvel OA, Simpson HB. Obsessive-compulsive disorder. Nat Rev Dis Primers. 2019 Aug 01;5(1):52.
6. Fontenelle JM, Santana LS, Lessa LR, et al. O conceito do insight em pacientes com transtorno obsessivo-compulsivo [The concept of insight in patients with obsessive-compulsive disorder]. Braz J Psychiatry. 2010;32:77–82.
7. David AS, Bedford N, Wiffen B, et al. Failures of metacognition and lack of insight in neuropsychiatric disorders. Philos Trans R Soc Lond B Biol Sci. 2012;367:1379–1390.
8. American Psychiatric Association (APA). Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5). Arlington, VA: APA; 2013.
9. Foa EB, Kozak MJ, Goodman WK, et al. DSM-IV field trial: obsessive-compulsive disorder. Am J Psychiatry. 1995;152:90–96.
10. Catapano F, Perris F, Fabrazzo M, et al. Obsessive-compulsive disorder with poor insight: a three-year prospective study. Prog Neuropsychopharmacol Biol Psychiatry. 2010;34:323–330.
11. Matsunaga H, Kiriike N, Matsui T, et al. Obsessive-compulsive disorder with poor insight. Compr Psychiatry. 2002;43:150–157.
12. Ravi Kishore V, Samar R, Janardhan Reddy YC, et al. Clinical characteristics and treatment response in poor and good insight obsessive–compulsive disorder. Eur Psychiatry. 2004;19:202–208.
13. Bloch MH, Landeros-Weisenberger A, Rosario MC, Pittenger C, Leckman JF. Meta-analysis of the symptom structure of obsessive-compulsive disorder. Am J Psychiatry. 2008;165(12):1532–1542.
14. van den Heuvel OA, Vriend C, Verwer B, de Haan E, van Megen HJ, van Balkom AJ. Item-level factor analysis and heritability estimates of OCD symptom dimensions. Behav Genet. 2010;40(6):505–517.

15. Kumar H, Ali I, Anamika, Devi B. Symptom Dimensions and Insight in Obsessive Compulsive Disorder. Int J Indian Psychol. 2016;3(4).
16. Abramowitz JS, McKay D, Storch EA. Symptom dimensions in obsessive-compulsive disorder: clinical and research implications. Psychiatr Clin North Am. 2009;32(3):529–540.
17. Zhang Y, Wang H, Fei P, et al. Study on symptom dimensions and clinical characteristics in patients with obsessive-compulsive disorder: a cross-cultural sample. Eur Psychiatry. 2025;
18. Stein DJ, Costa DL, Lochner C, et al. Obsessive-compulsive disorder. Nat Rev Dis Primers. 2019;5:52.
19. Hasler G, Duffau H, Leckman JF, et al. Are there familial patterns of symptom dimensions in obsessive-compulsive disorder? Front Psychiatry. 2021;12:651196.
20. van Grootheest DS, Cath DC, Beekman AT, Boomsma DI. Distinct etiological influences on obsessive–compulsive symptom dimensions: a multivariate twin study. Arch Gen Psychiatry. 2005;62(11):1139–1145.